U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 May 2003

CASE NO.: 2002-BLA-5357

In the Matter of:

WILLIAM O. DEMPSEY
Claimant

v.

SEWELL COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Mary Zanoli Natkin, Esq.
For the Claimant

Douglas Smoot, Esq.
For the Employer

Before: DANIEL L. LELAND
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by

pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Charleston, West Virginia on February 6, 2003, at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-36, 39, 41-48, Claimant's exhibits (CX) 1-8, and Employer's Exhibits (EX) 2, 6 (curriculum vitae of Dr. Wheeler only), 9, 10 (curriculum vitae of Dr. Renn only), 11, 12 (Dr. Wiot's interpretations of the October 1, 2002 and October 25, 2002 chest x-rays), 13, 15-16, 29-32 were admitted into evidence.[1] After allowing Employer forty-five days to review and submit rebuttal evidence to Claimant's late evidence, I issued Orders on April 8 and 14, 2003, excluding EX 33, 34, and 35, as they were cumulative rebuttal evidence and they violated § 725.414(a)(3)(ii). The April 8, 2003 Order also admitted EX 36 into the record.

ISSUES

I. Timeliness.

II. Existence of pneumoconiosis.

III. Causal relationship of pneumoconiosis and coal mine employment.

IV. Existence of total disability.

V. Causation of total disability.

VI. Material change in conditions.

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[1] I issued Orders on January 10, 2003 and January 27, 2003 in which certain evidence was excluded as exceeding the evidentiary limitations of the new regulations. *See* Appendix A for a copy of the January 10, 2003 Order Granting Claimant's Motion to Exclude Employer's Medical Evidence and Appendix B for a copy of the January 27, 2003 Order. I excluded DX 37, 38, and 40 because they contained pulmonary function studies and arterial blood gas studies that Employer had submitted to the District Director that exceeded the evidentiary limitations. Additionally, EX 1, 3-5, 7-8, 12 (Dr. Wiot's interpretation of the August 5, 2002 chest x-ray), 14, 17-28 were excluded because they contained chest x-ray interpretations, CT scan interpretations, and medical reports that exceeded the evidentiary limitations. Further, I found that Employer failed to establish good cause to admit the additional evidence pursuant to § 725.456(b)(1). *See* January 10, 2003 Order, p. 5; January 27, 2003 Order, pp. 2-3; TR 38.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[2]

Procedural History

William O. Dempsey (Claimant or miner) filed his first claim for benefits on April 27, 1989. (DX 1). That claim was denied by the district director on August 15, 1989 because there was no evidence that Claimant was totally disabled due to pneumoconiosis. (DX 1). Claimant filed the instant claim for benefits on February 8, 2001. (DX 3). On May 29, 2002, the district director awarded benefits and Employer requested a formal hearing on June 5, 2002. (DX 33, 41). The case was then referred to the Office of Administrative Law Judges on July 31, 2002 for a formal hearing. (DX 45).

Background

Claimant was born on November 29, 1936 and has one dependent, his wife, Barbara. (DX 3; TR 23). Employer stipulated that Claimant had twenty-three years of coal mine employment. (TR 10). Claimant testified that he worked for Sewell Coal Company between eleven and twelve years. (TR 25). Claimant's last job with Sewell Coal Company was as a belt repairman, which he held for three to four years. (TR 26). Claimant worked underground as a belt repairman, and he would have to carry steel pieces that weighed thirty or forty pounds when the belts needed to be repaired. (TR 26, 28). The hardest part of this job was pulling the belt together with the come-alongs, which required six or seven men. (TR 27, 30). When there were no belts to repair, Claimant would rock dust, set timber, set headers, and haul rails. (TR 28-29). Claimant testified that he could not work as a belt repairman today because he does not have "enough wind." (TR 30). After Claimant left Sewell Coal Company, he worked for Dale and Tina Coal Company for approximately three months and DC & M Coal Company for approximately five months. (TR 24-25). Claimant has not worked in the coal mining industry since March of 1989. (TR 32). Claimant worked for approximately three months for Glass Rock Home Health Care delivering oxygen, wheelchairs, and beds. (TR 32). Claimant left that job because he "did not have enough wind to load the big things." (TR 33). Claimant is currently not working. (TR 32).

Claimant testified that he has trouble breathing when he climbs stairs and does any physical work. (TR 33). Claimant sleeps with his bed elevated and also has trouble breathing during the day. (TR 33). Claimant testified that humidity also affects his breathing. (TR 33). Claimant has never smoked cigarettes and is not currently taking any medication for his breathing problems. (TR 33, 35).

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[2] The following abbreviations have been used in this decision and order: TR = transcript of hearing, BCR = board-certified radiologist, B = B-reader.

Medical Evidence

Chest x-rays[3]

Exhibit	Date	Physician	Interpretation
DX 1	11/20/76	Goerlich	1/2, q
DX 1	8/8/78	Goerlich	small cap of pneumothorax over the left apex; lungs are clear
DX 1	1/5/83	Goerlich	2/1, q
DX 1	2/10/89	Gaziano, B	2/2, q/t
DX 1	5/22/89	Gaziano, B	1/1, q/t
DX 1	5/22/89	Shah, BCR	2/1, s/p
DX 35	7/19/01	Wiot, BCR, B[4]	completely negative
DX 19/20	8/13/01	Patel, BCR, B	2/2, p/p
DX 21	8/13/01	Navani, BCR, B	only read quality of x-ray - classified as category 2 because of suboptimal parenchymal resolution
CX 3	8/13/01	Alexander, BCR, B	2/2, p/s

[3] In Claimant's brief, he states that Dr. Scott's interpretation of the August 13, 2001 chest x-ray was admitted into the record. *See Claimant's Closing Argument*, p. 12. Dr. Scott's interpretation was excluded from the record because it exceeded the evidentiary limitations of § 725.414(a)(3)(i). (TR 40). Also, Employer's brief states that Dr. Renn's interpretations of the May 22, 1989 and October 1, 2002 chest x-rays and Dr. Spitz's interpretation of the July 19, 2001 x-ray were admitted into the record. *See Employer's Closing Argument*, p. 7. Dr. Spitz's interpretation was excluded from the record because it exceeded the evidentiary limitations. (TR 40). The admissibility of Dr. Renn's interpretations was not specifically addressed at the hearing. I find that Dr. Renn's interpretations are not admissible because they exceed the evidentiary limitations of § 725.414(a)(3)(i). All references to the excluded x-ray interpretations in the parties' closing briefs are stricken from the record.

[4] Dr. Wiot's B-reader certificate states that his certification is effective until June 30, 1999. *See* DX 35. I take judicial notice of the NIOSH B-reader list, which states that Dr. Wiot is a certified B-reader from July 1, 1999 to June 30, 2003.

Exhibit	Date	Physician	Interpretation
EX 2	8/13/01	Wheeler, BCR[5]	completely negative
EX 12	10/1/02	Wiot, BCR, B	completely negative
CX 2	10/25/02	Alexander, BCR, B	2/1, p/s
CX 6	10/25/02	Cohen, B	2/2, q/s
EX 12	10/25/02	Wiot, BCR, B	completely negative

CT Scans

There are four interpretations of the October 31, 2002 CT scan in the record. Dr. Alexander stated that the CT scan demonstrated a small right pleural effusion which was not detectable on the October 25, 2002 chest x-ray. (CX 2). He also stated that the cardiomediastinal structures and distribution of the pulmonary vasculature were normal. Dr. Cohen stated that the CT scan showed scattered round and irregular opacities throughout both lungs. (CX 6). He stated that there were areas of more dense scarring bilaterally and noted that bilateral pleural thickening was more significant on the right than on the left. Dr. Wiot stated that the CT scan showed no evidence of coal workers' pneumoconiosis. (EX 13). He stated that there was pleural disease bilaterally, but explained that pleural disease is not a manifestation of coal dust exposure. Dr. Wiot stated that there was bibasilar and mid- zone interstitial fibrosis involving the lower lobes, but that the upper lung fields were completely clear. Dr. Scatarige stated that the CT scan showed no evidence of silicosis or coal workers' pneumoconiosis. (EX 29). He stated that there was very small right pleural effusion and possible minimal left pleural reaction. Dr. Scatarige also stated that there was a few non-perfused vessels in the right lower lobe compatible with segmental or subsegmental pulmonary embolus. Finally, he stated that there was minimal interstitial infiltrate/fibrosis in the right mid-lung and both lower lobes, which was non-specific.

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV1	FVC	MVV
DX 1	2/10/89	68"	52	3.08	4.47	115

[5] Dr. Wheeler's curriculum vitae and B-reader certificate state that his B-reader certification is effective until April 30, 2001. Dr. Wheeler interpreted this x-ray on March 20, 2002. I find that Dr. Wheeler was not a certified B-reader when he interpreted this x-ray, and thus he is not entitled to the status of a dually-qualified physician.

Exhibit	Date	Height	Age	FEV1	FVC	MVV
DX 1	5/22/89	70"	52	3.04	4.15	89
DX 34	7/19/01	68"	64	2.88 3.06*	4.30 4.12*	78 92*
DX 18	8/13/01	69"	64	2.85	4.54	97
EX 9	10/1/02	69"	65	2.78 2.96*	4.41 4.18*	95 91*

* results post-bronchodilator

Blood Gas Studies

Exhibit	Date	PCO2	PO2
DX 1	5/22/89	31 29*	73 86*
DX 34	7/19/01	33.6 30.9*	74.5 75.8*
DX 16	8/13/01	31 32*	70 66*
EX 9	10/1/02	25 26* 27*	91 80* 77*

* exercise values

The August 13, 2001 study was validated by Dr. Dominic Gaziano on December 14, 2001. (DX 16).

Medical Reports

Dr. Mark Wantz examined Claimant on May 22, 1989. (DX 1). Claimant's chief complaints were: daily cough, monthly wheezing, dyspnea, grayish sputum, chest pain with exertion, and paroxysmal nocturnal dyspnea. Dr. Wantz noted that Claimant never smoked cigarettes. The chest x-ray revealed parenchymal abnormalities of pneumoconiosis. The pulmonary function study revealed a mild obstructive component of the smaller airways, suggestive of mild air trapping. The arterial blood gas test was normal. The electrocardiogram

(EKG) revealed "NSR, anterior MI in past, no ischemic changes, left ventricular hypertrophy." (DX 1). Dr. Wantz diagnosed Claimant with pneumoconiosis and antecedent myocardial infarction. He stated that the pneumoconiosis is due to coal dust exposure and the myocardial infarction is due to heredity. Dr. Wantz opined that Claimant has a moderate impairment, and that his activity is limited due to dyspnea. He stated that eighty percent of Claimant's impairment is due to his pneumoconiosis and antecedent myocardial infarction.

Dr. D. L. Rasmussen, a board-certified internist, examined Claimant on August 13, 2001. (DX 15; CX 8, p. 5). Claimant's symptoms were: occasional wheezing, dyspnea upon exertion for thirteen to fourteen years, chronic, seldom productive cough, bilateral lower chest pain, and orthopnea. Dr. Rasmussen noted that Claimant never smoked cigarettes. The physical examination was normal. The chest x-ray was interpreted by Dr. Patel as 2/2, p/p. The pulmonary function study revealed a slight obstructive ventilatory impairment and the single breath carbon monoxide diffusing capacity was minimally reduced. Also, the arterial blood gas test revealed marked impairment in oxygen transfer with exertion. Dr. Rasmussen diagnosed Claimant with coal workers' pneumoconiosis based on his twenty-six years of coal mine employment and the chest x-ray evidence. He also diagnosed dyspnea on effort and atherosclerotic heart disease (ASHD) based on Claimant's cardiac catherization in 1990. Dr. Rasmussen stated that Claimant's coal workers' pneumoconiosis and dyspnea are caused by his coal mine dust exposure, and his ASHD is due to a non-occupational factor. Dr. Rasmussen concluded that Claimant has a moderate to severe loss of lung function that is due to his coal dust exposure. Dr. Rasmussen stated that Claimant does not retain the pulmonary capacity to perform his last regular coal mine job.

Dr. John A. Bellotte, a board-certified pulmonologist, examined Claimant on July 19, 2001, and summarized his findings in a report dated September 21, 2001. (DX 34).[6] Claimant's chief complaints were: dry, hacky cough with occasional sputum, wheezing when it is damp, shortness of breath on exertion, left-sided chest pain, orthopnea, and paroxysmal nocturnal dyspnea. He also noted that Claimant never smoked cigarettes. Claimant told Dr. Bellotte that he could walk one-half a mile, climb fourteen stairs, and lift approximately ninety pounds, but that he should not lift more than twenty-five pounds. The physical examination was normal. The pulmonary function study revealed a mild obstructive ventilatory impairment, which was not responsive to bronchodilator medication. He also noted a minimal impairment in Claimant's diffusing capacity. The electrocardiogram revealed a possible old inferior myocardial infarction. The arterial blood gas study was normal. Dr. Bellotte concluded that there is a mild pulmonary impairment, but opined that it is related to his cardiac deconditioning and some old granulomatous lung disease. Dr. Bellotte stated that Claimant is totally and permanently disabled due to his

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[6] Dr. Bellotte's report includes his interpretation of a chest x-ray dated July 19, 2001. His interpretation was excluded from the record because it exceeded the evidentiary limitations. All references to his x-ray interpretation in the September 21, 2001 report and his subsequent deposition testimony are stricken from the record.

cardiac and orthopedic conditions. However, from a ventilatory standpoint, Claimant is not disabled and he retains the ability to perform his last coal mine employment.

Dr. Bellotte reviewed Dr. Rasmussen's report and was deposed on March 18, 2002. (DX 36). Dr. Bellotte testified that Claimant's mild obstructive ventilatory impairment may be due to undiagnosed asthma and that his mild diffusing capacity impairment could be due to mild interstitial fibrosis. (DX 36, p. 18). He also testified that his testing and Dr. Rasmussen's testing were very similar, but that they interpreted the tests results differently. (DX 36, p. 22). Dr. Bellotte believes that Claimant can perform heavy work under either arterial blood gas test. (DX 36, p. 24). Dr. Bellotte reiterated his opinion that Claimant does not have a totally disabling pulmonary or respiratory impairment. (DX 36, p. 27).

Claimant was examined by Dr. Joseph J. Renn III, a board-certified pulmonologist, on October 1, 2002. (EX 9, 10).[7] Dr. Renn also reviewed Claimant's work history records and the medical opinions of Dr. Rasmussen and Dr. Bellotte, and his findings are summarized in his report dated November 15, 2002.[8] Claimant told Dr. Renn that he has had exertional dyspnea since 1978, a cough since 1995, sputum production since 1994, wheezing since 1993, and orthopnea. Dr. Renn noted that Claimant never smoked cigarettes, but he did use a can of snuff or a package of chewing tobacco every day from 1950 until 1970. The physical examination was normal. The electrocardiograph was normal. The spirometry revealed a mild obstructive ventilatory defect, but the post-bronchodilator study was normal. The lung volumes, by plethysmography, were normal. The diffusing capacity was invalid because Claimant failed to inspire to at least 90% or greater of his observed vital capacity. The cardiopulmonary exercise stress evaluation revealed exercise limited by muscular fatigue and a mild interference with gas exchange. Dr. Renn concluded that Claimant does not have pneumoconiosis, but that he does have idiopathic interstitial pulmonary fibrosis. Dr. Renn stated that "Claimant has no significant impairment of ventilatory function other than of gas exchange," but that it is not of sufficient degree to prevent him from performing his duties as a belt examiner. (EX 9, p. 6). Dr. Renn recommended that Claimant undergo a CT scan in order to determine what type of idiopathic interstitial pulmonary fibrosis is present.

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[7] Dr. Renn's report includes his interpretations of chest x-rays dated May 22, 1989 and October 1, 2002. His interpretations were excluded from the record because they exceeded the evidentiary limitations. *See supra* note 3. All references to his x-ray interpretations in his November 15, 2002 report, deposition testimony, and supplemental letters are stricken from the record.

[8] Dr. Renn also reviewed chest x-ray interpretations, pulmonary function studies, arterial blood gas tests, and medical records that are not in the record. (EX 9, pp. 2, 5-6).

Dr. Rasmussen was deposed on December 12, 2002. (CX 8; EX 16).[9] Dr. Rasmussen testified that Claimant retains the pulmonary capacity to perform heavy manual labor based on his pulmonary function study and diffusing capacity results. (CX 8, pp. 22-23). However, he testified that Claimant could not perform more than light labor with bursts of moderate labor based on his "rather significant gas exchange impairment with a significant reduction in his base excess and reduction in bicarbonate." (CX 8, p. 31). Dr. Rasmussen testified that Claimant's gas transfer with exercise impairment is consistent with coal workers' pneumoconiosis. (CX 8, pp. 31-32). He believes that Claimant's impairment is not due to his heart or obesity because neither congestive heart failure nor obesity cause hypoxia, and thus he concluded that it is due to his lungs. (CX 8, p. 38). Dr. Rasmussen testified that experience and the absence of collagen vascular disease or other recognizable causes of diffused interstitial fibrosis leads him to conclude that Claimant's lung disease is due to his coal mine dust exposure. (CX 8, p. 35).

Dr. Renn reviewed the August 13, 2001 arterial blood gas study and his conclusions are found in a letter dated December 30, 2002. (EX 15). Dr. Renn stated that the study "reveal[ed] a serious inconsistency between the resting values, albeit the second resting value was influenced by hyperventilation." (EX 15, p. 2). He also noted that Claimant remained hyperventilated throughout the study. He concluded that Claimant's "oxygen uptake at peak exercise exceeded that predicted for a 64 year old male and suggests that he should be capable of fairly heavy manual labor." (EX 15, p. 2).[10]

Dr. Dominic Gaziano, a board-certified pulmonologist, submitted an opinion letter dated January 24, 2003. (CX 4). Dr. Gaziano opined that Claimant has pneumoconiosis. He stated that irregular opacities occur in approximately fifteen percent of occupational coal workers' pneumoconiosis cases. Dr. Gaziano stated that, based on Claimant's occupational history and the chest x-ray findings, "there is [no] other credible explanation than pneumoconiosis as the cause of his x-ray findings." (CX 4, p. 1). Dr. Gaziano does not believe that Claimant has idiopathic pulmonary fibrosis because there has been no reduction in his pulmonary function tests, particularly the diffusing capacity, even though the chest x-rays reveal 1/1 or 2/2 degree of impairment. In addition, he stated that "idiopathic pulmonary fibrosis is a moderately rapidly progressive disease and [Claimant] would likely have been dead or at least be severely impaired by this time had he had idiopathic pulmonary fibrosis." (CX 4, p. 1).

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[9] Both Claimant and Employer submitted Dr. Rasmussen's deposition as an exhibit at the hearing. However, the only copy of the deposition in the record is at CX 8. Therefore, all references to Dr. Rasmussen's deposition will refer to that exhibit.

[10] During Dr. Renn's deposition on January 24, 2003, he testified that he did not invalidate the results of the August 13, 2001 arterial blood gas study. (EX 32, p. 67).

Dr. Renn was deposed on January 24, 2003.[11] (EX 32). Dr. Renn testified that the resting blood gases on the October 1, 2002 study were normal, however Claimant had an abnormal response to exercise from a pulmonary standpoint. (EX 32, p. 35). Dr. Renn opined that Claimant's gas exchange abnormality is due to interstitial pulmonary fibrosis. (EX 32, pp. 39-40). He testified that Claimant's condition is not consistent with a coal dust induced lung disease because Claimant has no wheezing, an occasional productive cough, and a gas exchange interference without a severely impaired diffusing capacity. (EX 32, pp. 40-41). Based on all of the studies, Dr. Renn concluded that, from a pulmonary standpoint, Claimant could perform moderately heavy labor, but the amount of time that he could perform such labor would be limited. (EX 32, pp. 38-39). He testified that Claimant would be able to perform heavy labor for six and one-half minutes, but that he would not be able to perform heavy labor for thirty minutes due to his gas exchange abnormality. (EX 32, pp. 39, 66). Dr. Renn also testified that Claimant would not be able to perform moderate labor for an entire workday (8 hours). (EX 32, pp. 66-67). Further, Dr. Renn testified that, based upon his understanding of the duties of a belt repairman and a belt examiner, Claimant retains the capacity to work as a belt examiner, but not as a belt repairman. (EX 32, p. 72).

Dr. Jerome Wiot, a board-certified radiologist, was deposed on January 24, 2003. (EX 31). Dr. Wiot testified that coal workers' pneumoconiosis always begins in the upper lung zones, and generally it begins on the right side. (EX 31, p. 15). He also testified that the opacities appear primarily small and rounded, but that some irregular opacities will appear in "almost all cases." (EX 31, p. 15). In contrast, Dr. Wiot testified that idiopathic pulmonary fibrosis (IPF) always begins in the lower lung zones and towards the edges of the lungs. (EX 31, p. 18). He testified that the type and distribution of opacities in coal workers' pneumoconiosis and IPF are different, "[s]o you don't even think about coal workers when you see IPF." (EX 31, p. 20). Also, Dr. Wiot testified that there is no association between coal dust exposure and IPF. (EX 31, p. 25). He testified that there is no evidence of coal workers' pneumoconiosis on the July 19, 2001, October 1, 2002, and October 25, 2002 chest x-rays, but that they did reveal bi-basilar fibrosis consistent with IPF. (EX 31, pp. 24, 26-27). In addition, Dr. Wiot testified that the October 31, 2002 CT scan did not reveal any evidence of coal workers' pneumoconiosis because the upper lung fields are clear, but it did reveal basilar interstitial fibrosis. (EX 31, pp. 31-32). Dr. Wiot concluded that there is no radiographic evidence of coal workers' pneumoconiosis. (EX 31, p. 32).

Dr. Rasmussen prepared a supplemental letter dated January 31, 2003. (CX 5). After reviewing Dr. Renn's December 30, 2002 letter, Dr. Rasmussen explained that the resting blood

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[11] Dr. Renn's deposition testimony includes his interpretation of the October 31, 2002 CT scan. Employer has already submitted two interpretations of this CT scan, and thus Dr. Renn's interpretation is not admissible because it exceeds the evidentiary limitations of § 725.414. All of Dr. Renn's deposition testimony regarding his interpretation of the CT scan is stricken from the record.

gas results of his test were not inconsistent because two resting samples were not taken, but rather resting, baseline, and exercise arterial blood gas samples were taken. He stated that the study "clearly show[ed] changes resulting from an increased body production of carbon dioxide with increased ventilation to remove the same. This is quite physiologic." (CX 5, p. 2). Dr. Rasmussen also stated that Claimant's arterial carbon dioxide ventilation dropped after exercise, which was a normal response to exercise. Finally, Dr. Rasmussen stated that Claimant's oxygen uptake was excessive for his exercise level, which often occurs in individuals who are performing unaccustomed to exercise or who are deconditioned.

Dr. Robert Cohen, a board-certified pulmonologist, reviewed the medical records and his conclusions are found in a report dated February 5, 2003. (CX 6). Dr. Cohen read the October 25, 2002 chest x-ray and the October 31, 2002 CT scan as positive for coal workers' pneumoconiosis. Dr. Cohen also reviewed the July 19, 2001 and August 31, 2001 pulmonary function studies. He stated that both studies were consistent with a mild obstructive defect and both studies revealed a moderate diffusion impairment with a low D1/Va. Dr. Cohen reviewed the July 19, 2001 and August 31, 2001 arterial blood gas tests. He stated that the July 19, 2001 study was "valid, internally consistent and show[ed] a clear ventilatory limitation to exercise at a work capacity which would be disabling for the heavy exertion of coal mine employment." (CX 6, p. 6). Dr. Cohen opined that Claimant suffers from coal workers' pneumoconiosis based on his twenty-five years of coal mine employment, that he was not a smoker and does not have a history of other significant occupational exposures, that he has symptoms of chronic lung disease (severe and progressively worsening shortness of breath, wheezing, and chronic cough), that the pulmonary function testing demonstrated a mild obstructive defect and a progressively worsening diffusion impairment, that the arterial blood gas studies showed significant gas exchange abnormalities with exercise with a clear ventilatory limit to exercise, and that there is chest x-ray evidence of pneumoconiosis. Dr. Cohen stated that Claimant does not have the classic radiologic features of idiopathic pulmonary fibrosis and that he "do[es] not believe that it is possible to attribute all of [Claimant's] pulmonary fibrosis to 'unknown' causes when we have 25 years of exposure to a substance which is well known to cause such scarring." (CX 6, p. 10). Dr. Cohen stated that Claimant's moderate diffusion impairment and significant gas exchange abnormalities with exercise left him unable to perform his jobs as a belt examiner and belt repairman, which required significant heavy exertion. Dr. Cohen concluded that Claimant was totally disabled from a pulmonary standpoint due to his pneumoconiosis.

After reviewing additional evidence, Dr. Renn prepared a supplemental letter dated March 17, 2003. (EX 36). First, Dr. Renn questioned the conditions of the August 13, 2001 arterial blood gas study, as the resting arterial blood gas sample was taken two hours before the exercise study was conducted. After a lengthy discussion of ratios and formulas, Dr. Renn stated that "Dr. Rasmussen's statement 'that [Claimant's] oxygen uptake was excessive for his exercise level' is entirely without foundation and known physiologic principles." (EX 36, p. 4). Dr. Renn reiterated his opinion that Claimant is capable of performing fairly heavy manual labor based on his oxygen consumption level. Next, Dr. Renn stated that Claimant's oxygen uptake level represents an approximately thirteen percent impairment according to the Fifth Edition of the

AMA's *Guides to the Evaluation of Permanent Impairment*, and he disagreed with Dr. Cohen's assessment that Claimant could not perform heavy coal mine work. He referenced several studies and stated that Claimant could still perform heavy manual labor with his level of oxygen consumption. Dr. Renn then disagreed with Dr. Gaziano's determination that Claimant does not have idiopathic pulmonary fibrosis. He cited to several published papers and stated that "Dr. Gaziano's comments are not well-founded in the scientific literature." (EX 36, p. 6). However, Dr. Renn also stated that his diagnosis of IPF "is a presumptive diagnosis, based upon probabilities, but is not proven until a lung biopsy is obtained." (EX 36, p. 6). Dr. Renn concluded that the reports of Drs. Cohen, Gaziano and Rasmussen do not alter his previously stated opinions.

Medical Records

The record includes office notes from Camden on Gauley Medical Center dated 1975 through 1983. (DX 1).

The record also includes the West Virginia Occupational Pneumoconiosis Board (WVOPB) determination letter dated February 1, 1978. (DX 1). The WVOPB found that there was sufficient evidence to justify a diagnosis of occupational pneumoconiosis with fifteen percent pulmonary impairment.

The record includes a letter from Dr. Gaziano to Dr. J. David Brown, Claimant's treating physician, dated February 13, 1989, regarding Claimant's January 25, 1989 bronchoscopy. (DX 1; CX 7). Dr. Gaziano noted that during the examination on February 10, 1989, Claimant was short of breath and had a productive cough. He stated that the bronchoscopy was negative for malignancy, the bronchial culture grew out normal flora, and the sputum was negative for acid fast bacilli and fungus.

The record also includes treatment records from Dr. Gaziano and Dr. Brown. (CX 1). Dr. Gaziano drafted a letter to Dr. Brown dated July 17, 1989, stating that he had examined Claimant on July 14, 1989. He stated that on examination Claimant had diminished breath sounds and that a chest x-ray showed "advanced" evidence of coal workers' pneumoconiosis. (CX 1, p. 1). Dr. Brown drafted a letter to the West Virginia State Board of Rehabilitation dated July 18, 1989, in which he chronicled the care he provided to Claimant for over thirty years. He concluded that Claimant is totally and permanently disabled from any type of gainful employment due to his chronic obstructive pulmonary disease due to pneumoconiosis. This opinion was reiterated in another letter to the West Virginia State Board of Rehabilitation dated October 17, 1989. Dr. Gaziano examined Claimant on August 15, 1989, and drafted a letter to Dr. Brown dated August 21, 1989. He noted Claimant's complaint of shortness of breath and that there were diminished breath sounds bilaterally upon examination. He stated that the chest x-ray revealed bilateral irregular and rounded opacities and he opined that Claimant has pneumoconiosis.

Conclusions of Law

Timeliness

Employer is contesting the timeliness of Claimant's application for benefits. (TR 10; DX 45). Section 725.308(a) provides that a claim for benefits "shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner..." However, in *Andryka v. Rochester & Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990), the Benefits Review Board (Board) held that the statute of limitations of § 725.308(a) does not apply to duplicate claims. As the United States Court of Appeals for the Fourth Circuit, within whose appellate jurisdiction this case arises, has not ruled on the issue, I find that the Board's holding is controlling. Employer has not presented any argument as to why the duplicate claim is untimely. Therefore, I find that the claim was timely filed.

Material Change in Conditions

This claim was filed after January 19, 2001, and is governed by the amended regulations. As the present claim is the miner's second claim for benefits, and it was filed more than one year after the denial of the miner's prior claim, the evidence must "demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final," or else the claim will be denied. § 725.309(d); *see also Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd*, 86 F.3d 1358 (4th Cir. 1996)(en banc), *cert. denied*, 117 S.Ct. 763 (1997). In the previous claim, the district director determined that the miner has pneumoconiosis arising out of coal mine employment, but that the evidence did not prove that he is totally disabled due to pneumoconiosis. Therefore, the evidence developed since the denial of that claim must initially prove that Claimant is totally disabled.

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right-sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. § 718.204(b)(2).

There were three pulmonary function studies admitted into evidence. None of the pulmonary function studies produced qualifying values. I find that the pulmonary function study evidence does not establish that Claimant is totally disabled.

There were three arterial blood gas tests admitted into evidence. Only the exercise portion of the August 13, 2001 arterial blood gas test was qualifying. Drs. Gaziano, Rasmussen and

Cohen validated this test. (DX 16; CX 5; CX 6). Dr. Renn questioned Dr. Rasmussen's testing methods, but he did not invalidate this test. (EX 32, p. 67). All of the physicians are in agreement that the August 13, 2001 test is valid, and I find that this arterial blood gas test is valid. However, I find that a preponderance of the arterial blood gas test evidence does not establish that Claimant is totally disabled.

There is no evidence that Claimant has cor pulmonale.

There are five physician opinions that address the issue of whether Claimant is totally disabled.[12] Dr. Rasmussen found that Claimant has a moderate to severe loss of lung function, and that he does not retain the pulmonary capacity to perform a job that requires more than light labor with bursts of moderate labor. Dr. Cohen concluded that Claimant is totally disabled from a pulmonary standpoint and is unable to perform the duties of a belt examiner or a belt repairman. Dr. Brown concluded that Claimant is totally and permanently disabled due to his severe shortness of breath and chronic obstructive pulmonary disease. Dr. Renn found that Claimant's interference with gas exchange is a significant ventilatory function impairment and that Claimant does not retain the capacity to work as a belt repairman, although he can still perform the duties of a belt examiner. Dr. Bellotte concluded that Claimant has a mild pulmonary impairment due to cardiac deconditioning and some old granulomatous lung disease. He stated that Claimant is able to perform heavy manual work from a ventilatory standpoint.

Since the physicians' opinions differ as to Claimant's usual coal mine work, I must first determine what was Claimant's usual coal mine work. The Board has defined "usual coal mine work" as the most recent job a miner performed regularly and over a substantial period of time. *Daft v. Badger Coal Co.*, 7 B.L.R. 1-124 (1984); *Shortridge v. Beatrice Pocahontas Coal Co.*, 4 B.L.R. 1-534 (1982). Claimant worked three months for Dale and Tina Coal Company and approximately five months for DC & M Coal Company. I find that his positions as a belt head cleaner and dispatcher for these coal companies do not qualify as "usual coal mine work" because Claimant did not perform these duties regularly and over a substantial period of time. According to Claimant's testimony, his last job with Employer was as a belt repairman. I find that Claimant was credible when he testified about the length of time that he worked as a belt repairman and the duties of a belt repairman. In addition, the employment records submitted by Employer, Claimant's deposition testimony on April 10, 2002, and the CM-911a that Claimant completed during his first claim for black lung benefits support Claimant's testimony that he worked as a belt repairman. (DX 1, 22, 23, 39, p. 4). Employer has offered no evidence to contradict Claimant's testimony that his usual coal mine work was as a belt repairman. Therefore, I find that Claimant's usual coal mine work was as a belt repairman. After considering Claimant and Dr. Renn's testimony, I also find that this position required heavy manual labor. (TR 26-30; EX 32, pp. 71-72).

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[12] Dr. Gaziano's opinion only discusses whether Claimant has pneumoconiosis, and thus is not probative on this issue.

Drs. Rasmussen, Renn, and Cohen concluded that Claimant's gas exchange impairment is significant and renders him unable to perform heavy manual labor. Drs. Rasmussen and Renn based their conclusions on Claimant's physical examination and the results of medical testing, and thus they are well-documented. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). I also find that their opinions are supported by the objective medical evidence. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90, n.1 (1986). I find that Drs. Rasmussen and Renn's opinions are well-reasoned because they explained how they determined that Claimant could not perform heavy manual labor based on the results of the arterial blood gas tests. For these reasons, I find that the opinions of Drs. Rasmussen and Renn are entitled to great weight.

Dr. Cohen did not examine Claimant, but he did have an opportunity to review all of the medical evidence in the record. A non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidation Coal Co.*, 7 B.L.R. 1-397 (1987). I find that Dr. Rasmussen's report and the evidence as a whole corroborates Dr. Cohen's opinion. I also find that Dr. Cohen's opinion is reasoned because the medical evidence supports his conclusions. *Fields*, 10 B.L.R. at 1-22. For these reasons, I find that Dr. Cohen's opinion is entitled to significant weight.

Dr. Brown found that Claimant is totally disabled due to severe shortness of breath and chronic obstructive pulmonary disease. Dr. Brown is Claimant's treating physician. I find that Dr. Brown's opinion is not entitled to extra weight because it does not comply with the requirements of § 718.104(d)(1)-(4). Specifically, there is no evidence that Dr. Brown was a specialist treating Claimant for his breathing problems, Dr. Brown saw Claimant sporadically over thirty years and treated him for a litany of health problems, and there is no evidence that he had a "superior understanding" of Claimant's health based on the frequency or extent of treatment. Further, I find that Dr. Brown's opinion is not well-reasoned because he merely asserts that Claimant is totally disabled without providing any documentation or reasoning for his conclusions. *Fields*, 10 B.L.R. at 1-22. For these reasons, I find that Dr. Brown's opinion is entitled to little weight.

Dr. Bellotte opined that Claimant does not have a totally disabling pulmonary or respiratory impairment and that he is able to perform heavy manual labor. Dr. Bellotte reviewed the August 13, 2001 arterial blood gas study and stated that it does not show any oxygen transfer impairment. (DX 36, p. 26). Dr. Bellotte's opinion contradicts the well-reasoned opinions of Drs. Cohen, Rasmussen, and Renn, who found that the August 13, 2001arterial blood gas study revealed a significant gas transfer impairment that prevents Claimant from being able to perform his usual coal mine employment. Further, Dr. Bellotte's opinion that Claimant's impairment is due to cardiac disease is based, at least in part, on evidence that is not in the record. (DX 36, pp. 4, 23). For these reasons, I accord Dr. Bellotte's opinion less weight than the opinions of Drs. Cohen, Rasmussen, and Renn.

As previously stated, I find that the position of belt repairman requires heavy manual labor, and based on the medical opinions of Drs. Cohen, Rasmussen, and Renn, Claimant is unable to perform his usual coal mine work. § 718.204(b)(1)(i). Therefore, I find that Claimant is totally disabled. Claimant has established an element of entitlement that was previously adjudicated against him. All of the evidence must now be evaluated to determine if Claimant is entitled to benefits.

Claimant has the burden of proving by a preponderance of the evidence that he has pneumoconiosis arising out of coal mine employment and that he is totally disabled as a result. *Gee v. W.G. Moore & Sons, Inc.*, 9 B.L.R. 1-4 (1986). A finding of the existence of pneumoconiosis may be based on chest x-rays, autopsies or biopsies, the presumptions in §§ 718.304, 718.305, or 718.306, and the reasoned medical opinion of a physician that the miner has pneumoconiosis as defined in § 718.201.[13] § 718.202(a)(1)-(4). All types of relevant evidence must be weighed to determine if the miner has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). There is no biopsy evidence and the enumerated presumptions are not applicable to this claim.

The record contains a total of fourteen interpretations of nine chest x-rays; of the fourteen interpretations, nine are positive for pneumoconiosis and five are negative for pneumoconiosis. In evaluating the chest x-ray interpretations, the qualifications of the physicians reading the x-rays must be taken into account. § 718.202(a)(1). The x-ray interpretations of physicians who are board-certified radiologists and B-readers are entitled to the greatest weight. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). Two dually-qualified physicians, Drs. Alexander and Patel, found radiographic evidence of pneumoconiosis and I accord greater weight to their opinions. One dually-qualified physician, Dr. Wiot, found no radiographic evidence of pneumoconiosis. Dr. Wiot testified in his deposition that Claimant's chest x-rays do not reveal coal workers' pneumoconiosis because there are no opacities in the upper lung zones, which is where pneumoconiosis first appears. (EX 31, pp. 15, 26). Instead, Dr. Wiot testified that Claimant's chest x-rays are consistent with idiopathic pulmonary fibrosis because only the lower lung zones are involved. (EX 31, pp. 24-27). Every physician that noted the location of the opacities on their interpretations found opacities in all six lung zones. Dr. Gaziano is the only physician who found opacities in the lower four zones on one x-ray, but he also found opacities in six lung zones on another x-ray. I find that the cumulative opinions of these physicians, which include a dually-qualified physician, a board-certified radiologist, and two B-readers, outweigh Dr. Wiot's opinion that the chest x-rays reveal idiopathic pulmonary fibrosis. For these reasons, I find that a preponderance of the chest x-ray evidence establishes the existence of pneumoconiosis.

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[13] Pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment, and it includes both medical, or clinical, pneumoconiosis and statutory, or legal, pneumoconiosis. § 718.201(a).

The record also contains four interpretations of the October 31, 2002 CT scan. Dr. Alexander, a dually-qualified physician, and Dr. Cohen, a B-reader, found evidence of pneumoconiosis on the CT scan, whereas two dually-qualified physicians, Drs. Scatarige and Wiot, found no evidence of pneumoconiosis on the CT scan. I find that the CT scan evidence is equipoise. Therefore, I find that the CT scan evidence does not establish the existence of pneumoconiosis.

The record includes the medical opinions of six physicians[14] and the findings of the WVOPB. Drs. Rasmussen, Gaziano, Cohen, Wantz, and Brown diagnosed Claimant with coal workers' pneumoconiosis. Dr. Renn stated that Claimant does not have pneumoconiosis, but rather diagnosed him with idiopathic pulmonary fibrosis.

Dr. Rasmussen diagnosed Claimant with coal workers' pneumoconiosis based on the positive chest x-ray evidence and his history of coal dust exposure. First, Employer calls Dr. Rasmussen's diagnosis into question because he relied on Dr. Patel's x-ray interpretation, even though his own interpretation of the x-ray was more consistent with interstitial pulmonary fibrosis. (CX 8, p. 20; *Employer's Closing Argument*, pp. 22-23). However, Dr. Patel is a dually-qualified physician, whereas Dr. Rasmussen is only a B-reader, and I find it reasonable that Dr. Rasmussen deferred to the opinion of a better qualified physician in interpreting the chest x-ray. Second, during his deposition, Dr. Rasmussen explained how he ruled out other possible causes of Claimant's lung disease. He testified that Claimant's lung disease was not due to his chemical exposure because there was no evidence that Claimant was suffering from a reactive airways disease. (CX 8, p. 15). Also, Dr. Rasmussen testified that Claimant's symptoms were not consistent with interstitial pulmonary fibrosis because there were no basilar rales upon chest examination and Claimant did not have collagen vascular disease or another recognizable cause of diffuse interstitial fibrosis. (CX 8, p. 35). I find that Dr. Rasmussen's explanations of how he ruled out the other causes of lung disease are clear and supported by the objective medical evidence. Further, I find that Dr. Rasmussen's opinion is well-reasoned and thus it is entitled to greater weight.

Dr. Cohen opined that Claimant has coal workers' pneumoconiosis based on his twenty-five years of coal mine employment, his symptoms of chronic lung disease, the positive x-ray evidence, and the results of medical testing. As stated above, a non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland*, 6 B.L.R. at 1-1289. I find that the evidence as a whole corroborates Dr. Cohen's opinion. I also find that Dr. Cohen's opinion is well-documented and well-reasoned because Dr. Cohen identified the medical evidence he relied upon in diagnosing Claimant and the medical evidence supports his conclusions. Further, I find

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[14] Dr. Bellotte's report is not considered on the issue of pneumoconiosis because his opinion is inextricably tied to his chest x-ray interpretation, which was previously excluded from the record.

that Dr. Cohen possesses impressive credentials related to diagnosing occupational lung diseases.[15] For these reasons, I find that Dr. Cohen's opinion is entitled to greater weight.

Dr. Gaziano examined Claimant on two separate occasions in 1989, and after each examination he diagnosed coal workers' pneumoconiosis. Dr. Gaziano's diagnosis is primarily based on his positive interpretations of the chest x-rays that accompanied the examinations. As a preponderance of the x-ray evidence is positive for pneumoconiosis, I find that Dr. Gaziano's opinion is supported by the x-ray evidence of record. In addition, Dr. Gaziano explained in his January 24, 2003 letter that the x-rays are not consistent with idiopathic pulmonary fibrosis because the degree of involvement revealed on the x-rays (1/1 or 2/2) would be accompanied by reductions on the pulmonary function studies, yet Claimant's spirometry results are normal. For these reasons, I find that Dr. Gaziano's opinion is entitled to more weight.

Dr. Wantz diagnosed Claimant with coal workers' pneumoconiosis based on a physical examination, a chest x-ray, and the results of medical testing. While Dr. Wantz did not specifically list the bases of his diagnosis of pneumoconiosis on page four of the Department of Labor's Form CM-988, *see Employer's Closing Argument*, p. 25, he did indicate on the third page that he reviewed and relied upon the chest x-ray, pulmonary function study, arterial blood gas test, and EKG. (DX 1). I find that this notation is sufficient to determine the bases of Dr. Wantz's diagnosis. As stated before, a preponderance of the x-ray evidence is positive for pneumoconiosis, and thus I find that Dr. Wantz's opinion is supported by the x-ray evidence of record. I also find Dr. Wantz's opinion to be well-reasoned, and thus is entitled to more weight.

Dr. Brown diagnosed chronic obstructive pulmonary disease due to pneumoconiosis. In order for chronic obstructive pulmonary disease to be considered legal pneumoconiosis, it must arise out of coal mine employment. *See* § 718.201(a)(2). Dr. Brown does not associate Claimant's chronic obstructive pulmonary disease with his coal dust exposure, other than to say that it is "due to pneumoconiosis." (CX 1, p. 3). However, stating that Claimant's chronic obstructive pulmonary disease is due to pneumoconiosis is not the equivalent of stating that it is due to his coal dust exposure, as pneumoconiosis is broadly defined as "a condition characterized by permanent deposition of substantial amounts of particulate matter in the lungs, usually of occupational or environmental origin, and by the tissue reaction to its presence." *Dorland's Illustrated Medical Dictionary* 1315 (28th Ed. 1994). As there are multiple origins of "pneumoconiosis," and there is no indication that Dr. Brown is applying the regulatory definition of pneumoconiosis, I find that Dr. Brown's has not diagnosed legal pneumoconiosis. In addition, Dr. Brown does not state the bases of his diagnosis of chronic obstructive pulmonary disease or

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[15] Dr. Cohen is a senior attending pulmonologist, Medical Director of the Black Lung Clinic, and Medical Director of the National Coalition of Black Lung and Respiratory Disease Clinics. He is also a consultant to the U.S. Mine Safety and Health Administration. Dr. Cohen is currently conducting research in the area of coal workers' pneumoconiosis in the Ukraine, and has lectured and published extensively on the issue of occupational lung diseases. *See* CX 6.

pneumoconiosis (i.e., Claimant's symptoms, physical examination results, clinical findings, etc.). Therefore, I find that Dr. Brown's opinion is not well-reasoned, and accord it less weight.

The WVOPB found the existence of occupational pneumoconiosis in its determination letter. While a state agency determination is relevant, it is not binding on this court. *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994). I find that the determination letter is not well-reasoned because the WVOPB stated their findings in the form of conclusions, without explaining the reasoning behind their conclusions. In addition, the WVOPB simply identified the medical evidence they relied upon; none of the evidence is appended to the determination letter. For these reasons, I accord less weight to the WVOPB's determination letter.

Dr. Renn concluded that Claimant has idiopathic interstitial pulmonary fibrosis. Dr. Renn based his opinion on an examination of Claimant and a review of numerous chest x-ray interpretations, pulmonary function studies, arterial blood gas tests, and medical reports by Drs. Bellotte and Rasmussen. However, a majority of the chest x-ray interpretations, pulmonary function studies, and arterial blood gas tests that Dr. Renn relied upon were excluded from the record because they exceeded the evidentiary limitations of the new regulations. *See supra* note 1. I find that Dr. Renn's opinion on the issue of pneumoconiosis is entitled to little weight because it is based on evidence not in the record. *Assuming arguendo* that Dr. Renn's opinion is based only on admissible evidence, I still find that it is not well-reasoned. Dr. Renn stated in his March 17, 2003 letter that his diagnosis of idiopathic pulmonary fibrosis "is a presumptive diagnosis, based upon probabilities, but is not proven until a lung biopsy is obtained." (EX 36, p. 6). I find that Dr. Renn's diagnosis of idiopathic pulmonary fibrosis is equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995). Also, a preponderance of the chest x-ray evidence is positive for pneumoconiosis, which undermines Dr. Renn's opinion that the x-ray evidence is consistent with some type of interstitial fibrosis. (EX 32, p. 28). Therefore, I accord little weight to the opinion of Dr. Renn.

In sum, I find that the opinions of Drs. Cohen, Gaziano, Rasmussen, and Wantz are well-reasoned and accord them great weight. I find that Claimant has established the existence of pneumoconiosis by a preponderance of the physician opinion evidence.

As stated above, I am required under *Compton* to weigh all of the evidence together to determine if Claimant has established the existence of pneumoconiosis. 211 F.3d at 211. I previously found that the chest x-ray and physician opinion evidence established coal workers' pneumoconiosis. After weighing all of the evidence together, I find that Claimant has established the existence of pneumoconiosis.

Claimant is entitled to the presumption in § 718.203(b) that his pneumoconiosis arose out of coal mine employment because of his twenty-three years of coal mine employment. Dr. Renn stated that Claimant did not have a coal dust induced lung disease because he did not have wheezing, his cough did not present until six years after he left the mines, and his cough was

occasionally productive. (EX 32, pp. 40-41). However, Drs. Bellotte, Gaziano, Rasmussen, and Wantz noted that Claimant reported symptoms of wheezing, cough, and occasional sputum production. In addition, Drs. Gaziano and Wantz reported that Claimant exhibited a productive cough in 1989, the year in which he left coal mine employment. I find that Dr. Renn did not have an accurate history of Claimant's symptoms, and thus I accord his opinion little weight. I find that this presumption has not been rebutted.

I previously found that Claimant established that he was totally disabled based on the medical opinions of Drs. Cohen, Rasmussen, and Renn. The first claim contains two pulmonary function studies, an arterial blood gas test, the medical opinion of Dr. Wantz, and the WVOPB determination letter. The pulmonary function studies and the arterial blood gas test did not produce qualifying values, and thus they do not establish that Claimant is totally disabled. Dr. Wantz found that Claimant has a moderate impairment and that his activity is limited due to dyspnea. While Dr. Wantz's opinion suggests that Claimant is totally disabled, he does not discuss whether Claimant is able to perform his usual coal mine work, as required by § 718.204(b)(1). I find that Dr. Wantz's opinion does not establish that Claimant is totally disabled. The WVOPB letter states that Claimant suffers a fifteen percent pulmonary impairment. For the reasons stated before, I find that the determination letter is poorly reasoned and accord it little weight. However, the evidence in the prior claim does not affect my conclusion that a preponderance of the newly submitted physician opinion evidence establishes that Claimant is totally disabled.

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it has a material adverse effect on his respiratory or pulmonary impairment or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. § 718.204(c)(1).

Drs. Rasmussen, Cohen, and Wantz found that Claimant is totally disabled due to pneumoconiosis.[16] Dr. Renn stated that Claimant's total disability is due to idiopathic pulmonary fibrosis. Dr. Rasmussen found that Claimant's gas exchange impairment, which is totally disabling, is due to pneumoconiosis. Dr. Rasmussen explained how he eliminated other factors (such as obesity and heart problems) as the cause of Claimant's impairment, and thus he was left

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[16] Dr. Brown's opinion is not considered on this issue because I previously found that his diagnosis of chronic obstructive pulmonary disease due to pneumoconiosis is not a diagnosis of legal pneumoconiosis, and thus his conclusion that Claimant is totally disabled due to chronic obstructive pulmonary disease due to pneumoconiosis cannot support a finding of total disability due to pneumoconiosis. Also, Dr. Bellotte's opinion is not probative on this issue because he did not find that Claimant is totally disabled. *See Scott v. Mason Coal Company*, 289 F.3d 263 (4th Cir. 2002).

with Claimant's coal dust exposure as the cause of his lung problems. (CX 8, pp. 35, 38). Dr. Cohen had the opportunity to examine all of the medical evidence of record and concluded that Claimant's coal workers' pneumoconiosis left him totally disabled and unable to perform his last three coal mining jobs. I find that Dr. Rasmussen's opinion is buttressed by Dr. Cohen's opinion that Claimant's total disability is due to pneumoconiosis. Further, I find that the opinions of both physicians are supported by the objective medical evidence. For these reasons, I find that the opinions of Drs. Cohen and Rasmussen are well-documented and well-reasoned and thus are entitled to great weight.

Dr. Wantz stated that eighty percent of Claimant's impairment is due to pneumoconiosis and myocardial infarction. It is not clear from Dr. Wantz's report if pneumoconiosis and myocardial infarction equally contributed to Claimant's impairment, or if one played a greater causal role than the other. I find that Dr. Wantz's opinion does not establish that pneumoconiosis is "substantially contributing cause" of Claimant's total disability, as required by § 718.204(c)(1), and thus is entitled to little weight.

Dr. Renn opined that Claimant's total disability is due to idiopathic pulmonary fibrosis. In *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 116 (4th Cir. 1995), the Fourth Circuit held that when an administrative law judge finds that the claimant has pneumoconiosis and is totally disabled, a physician's opinion to the contrary "can carry little weight." *See also Scott*, 289 F.3d at 269. However, the Court also stated that the physician's opinion can be given more weight if the administrative law judge "can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon [his] disagreement with the ALJ's finding as to either or both of the predicates in the causal chain." *Toler*, 43 F.3d at 116. I find that Dr. Renn's opinion that Claimant is totally disabled due to idiopathic pulmonary fibrosis rests on his finding that the chest x-ray evidence does not demonstrate that Claimant has coal workers' pneumoconiosis. Therefore, I find that Dr. Renn's opinion on the issue of causation is entitled to little weight.

After reviewing all of the evidence on the issue of causation, I find that a preponderance of the physician opinion evidence establishes that pneumoconiosis is a substantially contributing cause of Claimant's total disability.

The evidence establishes all the elements of entitlement. Benefits will be awarded as of February 1, 2001, the first day of the month in which the claim was filed. § 725.503(b). Claimant's counsel has thirty days to file a fully supported fee application and her attention is directed to §§ 725.365 and 725.366. Employer's counsel has twenty days to respond with objections.

ORDER

IT IS ORDERED THAT Sewell Coal Company:

1. Pay Claimant all the benefits to which he is entitled, augmented by one dependent, beginning as of February 1, 2001;

2. Pay Claimant all the medical benefits to which he is entitled beginning as of February 1, 2001;

3. Reimburse the Black Lung Disability Trust Fund for interim payments made to Claimant; and

4. Pay interest to the Black Lung Disability Trust Fund on unpaid benefits at the rates set forth in § 725.608.

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DANIEL L. LELAND
Administrative Law Judge

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NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601***. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.